

California Dental Loan Repayment Program: A Feasibility Study

Submitted to the Legislature
Pursuant to AB 668
(Chapter 249, Statutes of 2001)

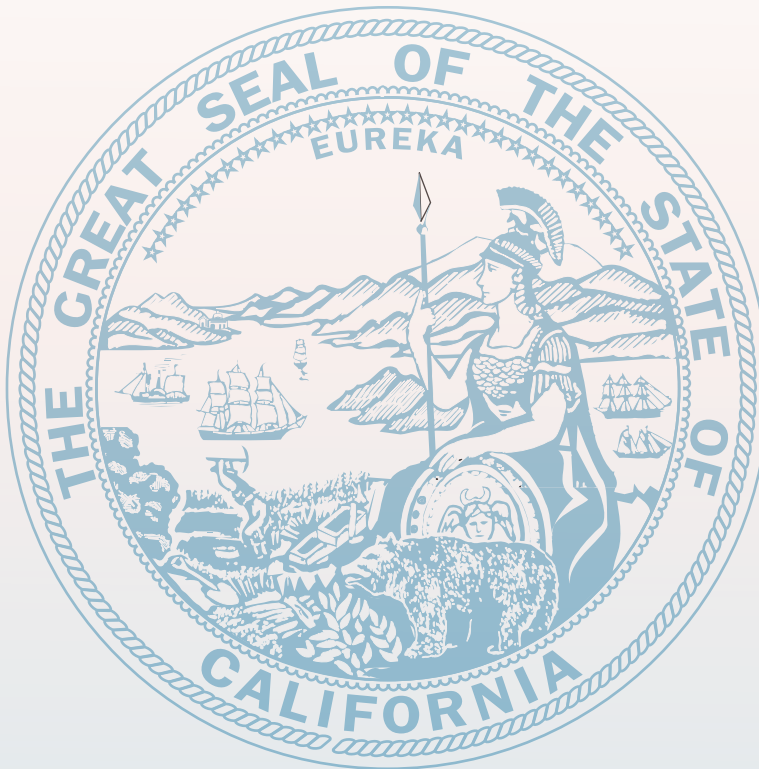
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Office of Statewide Health Planning & Development

California Dental Loan Repayment Program: A Feasibility Study

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State of California

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TABLE OF CONTENTS

I. INTRODUCTION AND SCOPE OF WORK	1
Introduction and Legislative History.....	1
Description of Existing OSHPD Program.....	1
Description of Legislative Mandate Relative to AB 668	2
II. POLICY BACKGROUND	4
Projection of Statewide Population-to-Dentist Ratios.....	4
Graph One: Projected Population to Dentist Ratios for California 2002-2012	5
Geographic Areas of Priority Need for Dentists	5
Projected Cost Increases of Private and Public Dental Schools.....	7
III. SIGNIFICANT PROGRAM IMPLEMENTATION ISSUES	8
Utilization by dentists of the loan repayment programs at the State and Federal levels	8
Analysis of costs and policy issues	10
APPENDIX A.....	15
APPENDIX B.....	22
APPENDIX C	23
APPENDIX D.....	24

I. INTRODUCTION AND SCOPE OF WORK

Introduction and Legislative History

The Office of Statewide Health Planning and Development (OSHPD) is directed by AB 668 (Chapter 249, Statutes of 2001) to study the feasibility of establishing a California Dentist Loan Forgiveness Program. In AB 668's statement of legislative intent, the California Legislature found that more than half of all children in California have untreated tooth decay. It cites National Health Service Corps (NHSC) officials who found that the federal program is able to address less than 12 percent of the identified nationwide need for dental services. The California Dental Association (CDA) testified that efforts to encourage dental school graduates to practice in areas of unmet priority need for dentists are made difficult by a combination of low reimbursement rates and the high student loan debt which most new dentists face when they graduate and begin practicing. According to CDA, a dental graduate's loan debt may exceed \$180,000.

OSHPD currently receives funding from NHSC to operate the California State Loan Repayment Program (CSLRP). As a result of its federal funding, CSLRP must operate in accordance with federal laws and regulations, including those related to the determination of dental shortages. However, OSHPD is permitted to determine the relative allocation of funds among the various categories of eligible health care providers, including dentists. The federal CSLRP funds must be matched dollar-for-dollar with non-federal funds. That match is made by the non-profit or governmental entity that employs the health professionals.

As a further condition of receiving loan repayment assistance, an eligible healthcare professional must agree to practice full-time (i.e., 40 hours a week) for a minimum of two years (up to four years) in a federally designated Health Professional Shortage Area (HPSA) or, in the case of dentists, a Dental Health Professional Shortage Area (DHPSA). OSHPD is also responsible for conducting an initial review of all federal shortage designation requests and for recommending whether or not those requests should be approved by federal authorities.

Proponents of AB 668 have noted several requirements of the CSLRP that they believe limit the ability of dental school graduates to avail themselves of its benefits. These requirements include the need for an employer to be a non-profit or public entity that provides free care or utilizes a "sliding fee scale" based on patient income and family size. As a consequence, private dentists' offices are not eligible employers. Another is the requirement that the dentists receiving CSLRP assistance must work "full time." Full time is defined as a minimum of 40 hours per week, of which no less than 32 will be in direct patient care. Other limitations include the restriction of eligible employment sites to those located in federally designated DHPSAs.

OSHPD is directed to study the feasibility of establishing a State program that would define "qualifying dental practice sites," and would allow qualifying practice sites to include a private dental practice.

Description of Existing OSHPD Program

OSHPD's responsibility for administering the CSLRP commenced in Federal Fiscal Year (FFY) 1992. The stated mission of the loan repayment program is "to increase access to primary care

services and reduce health disparities for people in health professional shortage areas by assisting communities through site development and the placement of primary care health professionals in Health Professional Shortage Areas of California.” However, dentists were not added as an eligible health professions category until FFY 1995.

OSHPD administers the program through its receipt of a \$1 million annual grant award from the NHSC (which is located within the federal Health Resources and Services Administration). There has been no State general fund or other augmentation to the CSLRP’s federal funding. Under this program, OSHPD is authorized to repay outstanding government and commercial loans incurred during undergraduate or graduate education, including both principal and interest. The program offers loan repayment to primary care physicians (MD, DO), nurse practitioners, physician assistants, certified nurse midwives and dentists (DDS, DMD) who are willing to provide care in the federally designated HPSAs and DHPSAs within the State.

Health professionals participating in this program must practice in public or non-profit settings approved by OSHPD, and, therefore, cannot establish private practices. In return, loan repayment in the amount of \$25,000 (per year) for two years of service and \$35,000 (per year) for a third and a fourth year of service is granted. However, only 50 percent of those amounts are funded by the CSLRP. The other 50 percent must be provided as a matching contribution by the qualified public or private non-profit organization that wishes to employ the eligible practitioner. As a consequence, the required match is \$12,500 each year per recipient in the first and second years, and \$17,500 in the third and fourth years.

The applicable NHSC rules do not impose an upper limit on either the amount of loan repayment assistance that one health professional can obtain, or the allowable term of a loan repayment contract. However, the CSLRP chose to adopt rules that limit a single health professional to four years of loan repayment assistance.

The \$1 million California receives annually from the NHSC is the maximum amount permitted any one state. Because the program permits loan repayment to all the provider categories on a first-come, first-served basis, the demand exceeds the amount of funds available.

Applications are accepted on a continuous basis, until the funds from the annual appropriation are exhausted. The program’s experience during its first 10 years is that applications for funds and funds available have been approximately in balance. However, in 2002, the program expended all of its annual appropriation in May, four-and-a-half months prior to the end of the FFY.

Description of Legislative Mandate Relative to AB 668

The Legislature has directed that OSHPD prepare a report that:

- a) projects the statewide ratio of dentists to the California population (page 4),
- b) discusses the “dentally underserved” areas of the State (page 5),
- c) addresses the increasing debt burden of dental school graduates (page 7),
- d) discusses the barriers to more widespread use of the CSLRP (page 8), and
- e) explores the feasibility of creating an exclusively State-funded program modeled on the CSLRP but that utilizes less restrictive eligibility rules, including shortage designation

criteria promulgated by the California Health Manpower Policy Commission in place of the current federal criteria (page 10).

In developing its responses, the Office requested information and other input both from State agencies involved with the collection of relevant data and/or the oversight of dental health professionals, and from the California Oral Health Access Council (COHAC). The COHAC is the non-partisan deliberative body of the Oral Health Access Initiative (OHAI), an initiative being co-sponsored by approximately 30 statewide and regional organizations representing safety net and related interest groups. The COHAC is composed of dental educators, providers, and others concerned about California's oral health underservice problems, appointed by OHAI co-sponsoring organizations. Co-sponsoring and interested organizations and their respective COHAC designees are listed in Appendix D.

II. POLICY BACKGROUND

Projection of Statewide Population-to-Dentist Ratios

AB 668 (Chan) (Section 128040 (b) (1) (A)) requires a projection of the dentist-to-population ratio for California in the next decade. To forecast the ratio, OSHPD utilized Department of Finance statewide population growth projections and made specific assumptions about changes in the supply of practicing dentists in California over the period. The first task was to determine what is the full-time equivalent (FTE) number for practicing dentists in California. OSHPD compared federal Health Resources and Services Administration (HRSA) and the Dental Board of California figures, taking into account decreasing average workweek hours. The resulting estimate was 20,000 practicing FTE dentists for a ratio of one FTE dentist to 1,700 Californians.

Although no precise data exist on future numbers of dentists, several key factors appear to have the potential to impact their availability in California significantly. First, the United States Census Bureau projects that the State population will grow at a rate of 1.9 percent per year (20.7 percent over 10 years). In order to maintain a constant ratio of dentists-to-population, the number of dentists in practice would need to increase by the same percentage during the next decade.

However, it is doubtful that the growth rate in the number of dentists will equal population growth. Large numbers of dentists who graduated from dental schools in the 1950s and 1960s are expected to retire and, according to the American Dental Association (ADA), the average amount of time allocated to clinical practice by individual practitioners is decreasing. The entry of dentists from outside the United States is expected to decrease as new restrictions on immigration are established. The capacity for dental school enrollment growth appears to be circumscribed. Dental school enrollment rates in California and nationwide are declining, and at least, within the State, this trend is expected to continue (currently, the five California dental schools graduate approximately 520 dentists each year). Although historically there has been a net in-migration of dentists from other states, it appears unlikely that such net in-migration, even if it continues, would accelerate to the levels necessary to ensure that the dentist-to-population ratio will not worsen.

These assumptions may prove to be too pessimistic. However, even if California's aggregate dentist-to-population ratio does manage to remain constant, the access-related adequacy of that ratio is open to debate. The subsequent part of this chapter discusses the geographic maldistribution of California dentists, particularly in rural and low-income inner-city areas. However, even in those geographic areas that appear by some criteria to have adequate numbers of dentists, various population groups may still encounter insurmountable access barriers.

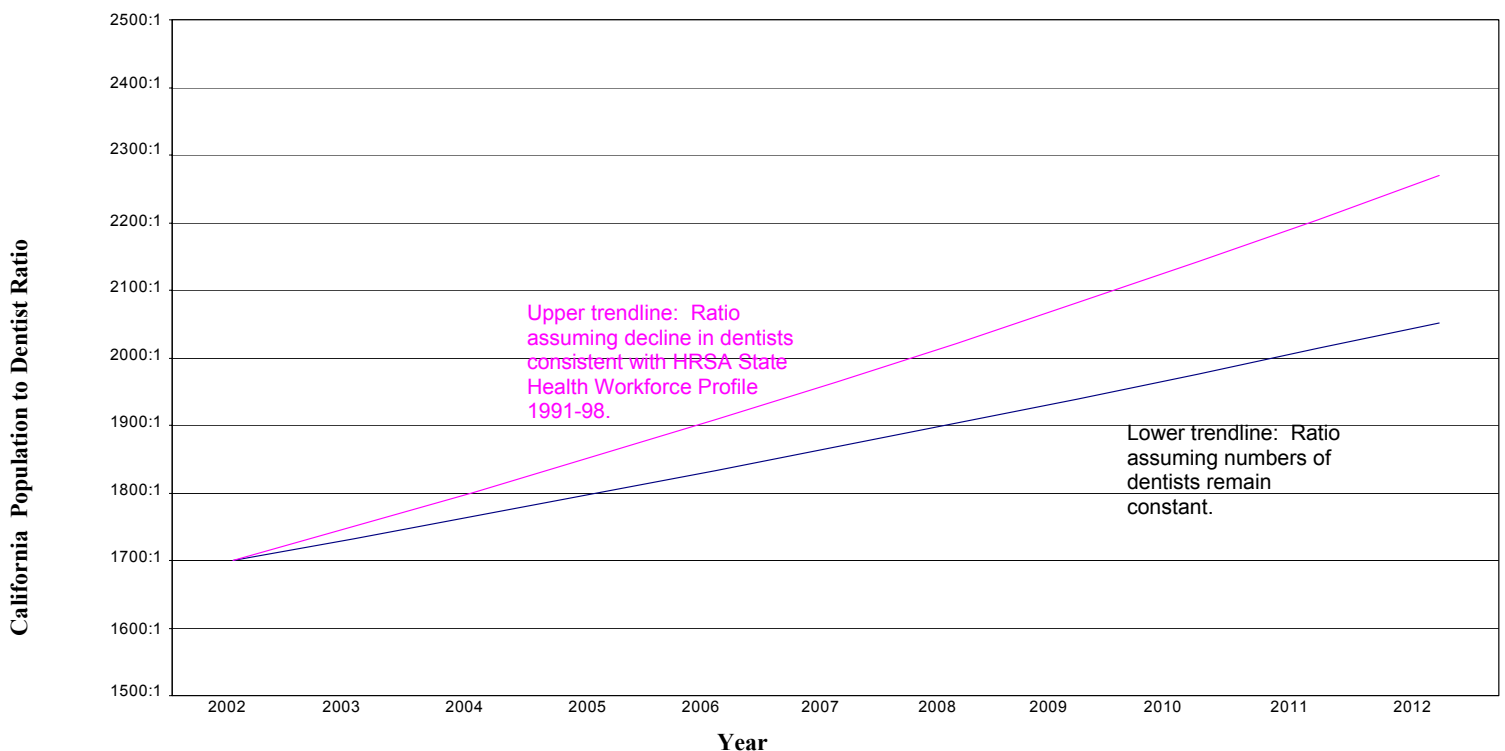
Such barriers may include discrimination based on lack of insurance or source of insurance coverage (e.g., Denti-Cal and Healthy Families), cultural and linguistic differences between consumers seeking service and available practitioners, and full practice panels with no clinical time available for allocation to currently underserved persons regardless of their payment status or other characteristics.

Ultimately those areas may also need a larger number of practicing dentists. Other factors to be considered include the changing nature of California's growing population. Much of the growth is being fueled by immigration from non-English speaking developing nations, and by increasing

numbers of both children and the elderly. Individually and in combination, these and other factors are likely to increase significantly both the need and resultant demand for increased access to dental care. It should be noted that California's traditional and current regulatory framework essentially makes the licensed dentist the exclusive entry point to all forms of oral health care, including basic preventive care such as oral prophylaxis and the application of sealants and topical fluoride. As a consequence, those critical services require the availability of a willing dentist.

Graph 1 displays these two assumptions regarding the availability of dentists. The lower trend line portrays the projected increase in numbers of Californians per practicing dentist, if the number of dentists remains constant and the population grows as expected. The upper trend line projects the increase in Californians per dentist if the number of practicing dentists decreases by a tenth of a percent per year. Such a rate approximates the decline noted between 1991 and 1998 in the United States Health Resources and Services Administration's State Health Workforce Profile for California dentists.

Graph 1: Projected Population to Dentist Ratios for California 2002-2012



Geographic Areas of Priority Need for Dentists

Section 128040 (b) (1) (B) of AB 668 requires that OSHPD determine the future need for dentists and dental care in underserved communities. The Office is directed to work collaboratively with organizations that represent providers of dental services to underserved communities in making this determination.

OSHPD's present responsibilities include two separate, but interrelated, activities that have bearing upon the declaration of geographical areas of dental need. Monitoring healthcare disparities within California is one of OSHPD's interests. OSHPD also has the responsibility to provide the State's response to the United States Department of Health and Human Services (USDHHS) to any proposal to declare federally recognized DHPSAs in California.

In the case of primary care medical and dental services, a geographic framework of sub-county and sub-city units called "medical service study areas" (MSSAs) is used. Each part of the state is in one of approximately 500 MSSAs, whose boundaries are established by the California Health Manpower Policy Commission. The MSSAs, which are comprised of groups of census tracts that are aggregated following general rules, provide a mechanism for analyzing the geographic distribution of primary care physicians and dentists. Although the MSSAs were originally developed for State programs, modifications were made in the MSSAs in order to meet criteria to define "rational service areas" acceptable to USDHHS.

To assess the geographic distribution of dentists within California, OSHPD contracted with the University of California San Francisco Center for Health Professions (UCSF-CHP). (Maps displaying the results of this study are included in Appendix A.) The study demonstrated that, like physicians, dentists in California tend to be concentrated in specific areas of the State, and that rural and low-income urban areas tend to have much lower dentist-to-population ratios.

UCSF-CHP organized data on the practice locations of California's dentists by MSSA, and then calculated the population-to-provider ratio for each MSSA. The principal federal criterion for declaring a DHPSA is that an area¹ with more than 5,000 persons for one primary care dentist is underserved. Therefore, UCSF-CHP identified which of California's MSSAs met or exceeded that threshold.

Because each MSSA is determined by the California Health Manpower Policy Commission as "rural" or "urban," UCSF-CHP was able to determine that statewide there were 1.8 general practice dentists for each 5,000 Californians living in rural areas, and 3.1 dentists in urban areas. However, it was also determined that significant numbers of both urban and rural Californians live in geographic areas that appear to be eligible for DHPSA designation. Of the undesignated urban MSSAs, 31 (11 percent) had populations that exceeded the 5,000:1 standard, as did 66 of the rural MSSAs (33 percent).

The process for obtaining formal designation of DHPSAs differs from the methodology employed by UCSF-CHP. The federal process reacts to applications from persons or organizations seeking designation of a specific area. Thus, many MSSAs that appear to qualify as a DHPSA in the UCSF-CHP study, including some of the State's poorest communities, are not on the federal DHPSA list, simply because no one has invested the considerable staff time and other resources required to obtain the designation.

Although some areas that appear to qualify as DHPSAs might be denied after federal review of the resources of contiguous areas, the federal DHPSA list appears to understate substantially the areas

¹ Federal policies for establishing Dental HPSAs [DHPSAs] permit a larger service area than for the Medical HPSAs. For example, 40 minutes travel time to the DHPSA center is permitted as opposed to 30 minutes travel time for HPSAs. By agreement with the HRSA Shortage Designation Branch, medical service study areas established by the California Health Manpower Policy Commission are the basic units on which HPSAs and DHPSAs are based. In California, DHPSAs may be comprised of either MSSAs standing alone or in combination.

that would qualify because of population-to-dentist ratios. Conversely, because there are circumstances that also qualify areas as DHPSAs that have a ratio of population-to-dentist in the range of 4,000-5,000, the UCSF-CHP calculations may understate significantly the number of MSSAs that meet the federal DHPSA criterion were formal designation requests prepared and submitted for review.

Projected Cost Increases of Private and Public Dental Schools

AB 668 (Section 128040 (b) (1) (D)) requires a report on the projected cost increases of dental school education (i.e., expense to the student) at public and private post-secondary educational institutions. In response, the Office requested information from California's five schools of dentistry and a representative sample of out-of-state schools regarding their projected cost increases for dental education. The projected cost increases range from three to six percent between now and 2010.

The projections for each of these dental schools average cost provide ample evidence that student costs for a four-year dental education is considerable. Such costs include university tuition, university specialty fees, and the cost of living expenses. All of the schools offer financial assistance to students through scholarships, grants or loans. But the amount of financial assistance through scholarships and grants available per individual is limited. Therefore, a dental student typically finances the major portion of his or her education with loans, resulting in high indebtedness at graduation.

For example, UCSF-CHP projected the average cost per year for dental school graduates of the entering dental school classes for academic years 1999 through 2007 (i.e., the classes scheduled to graduate in 2003 through 2010, respectively). UCSF-CHP expects the Class of 2003 to graduate with average per-student debt exceeding \$120,000, with average indebtedness exceeding \$170,000 by 2010. By extension, one expects average indebtedness from California's private sector schools to be significantly greater.

The following table displays the costs of dental education at public and private sector schools throughout the nation. The data calculate the average four-year costs for "resident" and "non-resident" dental students, as most public sector schools (and some private sector schools outside of California) typically subsidize the tuition and other costs of students who are residents of their states.

<i>Nationwide Average Costs</i>	<i>Resident</i>	<i>Non-Resident</i>
Public Institutions	\$59,200	\$110,200
Private Institutions	\$133,100	\$141,400

The following table displays average current cost of a four-year dental education among the California Schools of Dentistry for the class graduating in 2002:

INSTITUTION	<i>Total Expenses, Resident (including tuition)</i>	<i>Total Expenses, Non-Resident (including tuition)</i>	<i>Status</i>
University of California, Los Angeles	\$71,800	\$112,800	Public
University of California, San Francisco	\$73,200	\$114,200	Public
Loma Linda University	\$138,200	\$138,200	Private
University of the Pacific	\$173,643	\$173,643	Private
University of Southern California	\$178,300	\$178,300	Private

III. SIGNIFICANT PROGRAM IMPLEMENTATION ISSUES

Utilization by dentists of the loan repayment programs at the State and Federal levels

AB 668 (Section 128040 (b) (1) (C)) requires a report on the utilization by dentists of federal and state loan repayment programs, identifying the barriers to full utilization of these loan repayment programs.

The sole governmental source of dental school loan repayment assistance in California is the National Health Service Corps [NHSC]. There are two separate processes by which NHSC funds are distributed. One process is fully funded by the NHSC and operates on a nationwide basis. Under this program, decisions as to what dentists and what communities will receive the loan repayment contracts are made by federal officials in accordance with national priorities. The other process for distributing funds is through the CSLRP, in which all NHSC funds must be matched dollar for dollar with non-federal funds. California can allocate the dollars among eligible provider categories in whatever way it chooses, so long as the program otherwise is conducted in accordance with the applicable federal rules.

Some perceived barriers are common to both of the funded NHSC programs, and are a result of restrictions imposed by NHSC's authorizing legislation and implementing regulations. For example, both require full-time practice at a site physically located within the federally designated DHPSA. No matter how dentally underserved a community or population appears to be, no dentist can receive an NHSC contract unless the area in which he or she proposes to practice has been certified as a DHPSA by federal authorities. This requirement has had an adverse impact on many safety net organizations who may draw underserved patients from multiple MSSAs, but who may be located physically in an MSSA that itself does not meet the federal population to dentist standard and cannot, therefore, be designated.

NHSC's national program is governed by an additional set of rules requiring the relative prioritization of DHPSAs nationwide. Thus, in a given year, it is possible for virtually all NHSC

dental loan repayment to be allocated to higher priority DHPSAs in states and territories other than California. Moreover, to receive loan repayment funds, a qualified dentist must choose a high priority practice site, since the sites seeking dentists are prioritized and the federal NHSC staff is engaged in recruiting dentists for those high priority sites.

On the other hand, dentists who wish to utilize the CSLRP must find and secure positions at eligible sites on their own, as recruitment assistance is not available. Even if the dentist is willing to practice in any CSLRP-approved site, he or she still must find a site that is willing to provide the required 50 percent non-federal match. Conversely, if the dentist seeks a position in a non-profit or government entity that has not been certified as an eligible site and wishes to obtain loan repayment assistance, that person must persuade the potential employer to apply for certified eligible site status². All employers receiving CSLRP positions must agree to the dollar-for-dollar matching fund requirements, and must sign a memorandum of understanding with the State of California (OSHPD) that all of the requirements will be met.

The following chart displays the eligibility criteria required of dentists receiving CSLRP contracts:

<u>Eligibility Requirements for Dentists</u>	
Applicants must meet the following requirements at the time of application	
•	Be a U.S. citizen with a current and unrestricted California license to practice dentistry
•	Be free of unserved obligations for service (local, State, and Federal)
•	Be free of judgments arising from any federal debt
•	Be committed to providing dental services in a DHPSA
•	Be committed to practicing full time (defined as a minimum of 40 hours per week for at least 45 weeks per year)
•	Agree to enter into a service contract with OSHPD for a minimum of two consecutive years

The following table displays the maximum awards available under the CSLRP for each year of obligated service. From the standpoint of the individual dentist receiving loan repayment, the NHSC national and CSLRP awards are identical. However, as noted above, the CSLRP has chosen to limit its awards to no more than four years.

Loan Repayment Awards			
Service Year	State Award	Practice Site Match	Yearly Totals
1	\$12,500	\$12,500	\$25,000
2	\$12,500	\$12,500	\$25,000
3	\$17,500	\$17,500	\$35,000
4	\$17,500	\$17,500	\$35,000
Four -Year Award Total			\$120,000

The NHSC California State Loan Repayment Program incorporated the dental loan repayment component in October, 1994. In the ensuing eight FFYs, loan repayment contracts have been

² The application for Certified Eligible Site requires documentation of non-profit corporate status or certification as a government entity, as an employer observing prevailing wage rates for dentists, acceptance of assignment for Medicare and Medicaid patients, observance of policies of nondiscrimination against patients based on ability to pay or on characteristics such as race, certification of intent to provide culturally competent care, and agreement to utilize continuous quality improvement systems.

awarded to 20 dentists, 18 of whom served the required two years and two that extended their commitments into a third or fourth year. Of those 20 dentists, 14 served in rural DHPSAs and six in urban. (Appendix B provides a chart that shows the distribution of CSLRP awards between rural and urban areas, by health professional category and fiscal year. Appendix C displays a list of the certified eligible sites for dentists who have received contracts.)

Although the typical award is \$50,000 of dental loan repayment for two years of obligated service, the two-year service minimum is required, even if the applicant does not have \$50,000 of qualified loans to be repaid.

The CSLRP requires that each participating loan repayment site be designated as a “certified eligible site” by OSHPD. As of June 30, 2002, there were 33 certified eligible dental sites. The following chart displays the criteria that a certified eligible site must meet:

Eligibility Requirements for Certified Eligible Sites for Dentists

Practice sites must meet the following requirements at the time of application:

- Be a public or not-for-profit entity
- Be located in federally designated DHPSA
- Be committed to employing a dentist full time, for a minimum of two consecutive years and up to four years if mutually agreeable
- Hire the dentist at salaries based on prevailing rates in the area
- Agree to match OSHPD’s loan repayment award, on a dollar-for-dollar basis, in addition to salary; agree to pay the match with non-federal funds (i.e., revenues from State or local governments and the private sector, no part of which represents an appropriation of Federal funds); and agree to make the loan repayments directly to the dentist’s lending institutions
- Agree not to use OSHPD’s award or the match as means to reduce health professional salaries or offset health professional salaries (e.g., deduct the loan repayment match from paychecks)
- Agree to enter into a Memorandum of Understanding with OSHPD

Whether or not the CSLRP shortage designation, dollar match, or other rules deter larger numbers of dental school graduates from availing themselves of the program may prove to be moot, however. The annual allocation of funds to the CSLRP for FFY 2002 was subscribed fully by mid-May. The \$620,000 in contract awards consisted of 14 primary care physicians (nine family practice, five internal medicine), seven dentists and one physician assistant, with the remaining \$380,000 allocated to contracts in process. Expressions of interest by potential applicants indicate that demand for funds from the anticipated FFY 2003 allocation is likely to be even greater.

Analysis of costs and policy issues

AB 668 (Section 128040 (b) (1) (E)) required an analysis of the costs and a report on the implications of administering an additional program.

Question One: Is it feasible to develop a dental loan repayment program that utilizes a different method of identifying dental areas of need than processes already established by the Shortage Designation Branch of the United States Department of Health and Human Services?

If the dental loan repayment program is to utilize NHSC funds, it would be bound by whatever federal criteria were established to define and prioritize need (unless authority to designate need areas is delegated to states in the future). However, if the program is established utilizing funds from sources other than the NHSC, the program could be developed with entirely different criteria. In fact, the California Health Manpower Policy Commission (CHMPC) has statutory authority to declare “areas of unmet priority need for primary care family physicians” (Song-Brown Family Physician Training Act). The Commission also has the authority to declare “geographical rural areas where unmet priority need for medical services exists” (Garamendi Rural Health Services Act).

To respond to these legislative mandates, the Commission developed the geographical framework of sub-county and sub-city areas called medical service study areas (MSSAs). OSHPD has organized United States Census Data by MSSAs, and has the capacity to sort any existing data base on dental practices by MSSAs.

The results of the UCSF-CHP study on distribution of dentists by MSSAs, discussed in Chapter II of this report, suggest that the conceptual and technical means may exist to identify MSSAs with dental availability disparities in California. It appears likely that “geographical areas of unmet priority need for dental services” might be identified utilizing the UCSF-CHP approach (i.e., identifying all MSSAs below identified thresholds of population-to-dentist). The number of eligible sites identified in this manner almost certainly would be more extensive than the number identified through the current federal DHPSA process. CHMPC criteria for declaring dental underservice could also identify underserved population groups or special situations where other factors than dentist-to-population ratio could be considered.

Because the State would examine each MSSA prospectively to determine if it met criteria for being declared dentally underserved, it would differ markedly from the federal requirement that applications be made on a community-by-community basis. This likely would remove a principal concern of proponents of AB 668 — that the federal DHPSA application procedures are burdensome, consuming valuable time and resources, and thereby imposing unwarranted costs on applicants.

And, finally, CHMPC permits anyone to petition for a review of an area they believe has been improperly placed on or excluded from a list of need areas. Thus, additional work could be scheduled to examine any MSSA whose status was controversial.

Question Two: Is it feasible to develop a dental loan repayment program not utilizing NHSC funds?

The CSLRP differs substantially from loan repayment programs in other states that receive NHSC funds. California was the first state to satisfy the required “non-federal” match without appropriating any general fund revenues. Instead, as an absolute condition of participation in the CSLRP, employers of the loan repayment obligees are required to provide the 50 percent non-federal match. Thus, every loan repayment match requires a contract between the individual loan repayment recipient and OSHPD and an accompanying memorandum of understanding with the recipient’s employer. The contract specifies the recipient’s obligations and the consequences of default. The memorandum of understanding assures that the employer will meet the match and other applicable requirements of the CSLRP. These same mechanisms could be utilized to administer a State-funded dental loan repayment program.

Funding sources for such a program might include general fund appropriations, funds derived from professional license fees, or funds collected from foundations or other non-governmental organizations might be established to provide half of the funds allocated to loan repayment. Employers could then match these funds using either their own funds or funds provided by other non-profit entities, regardless of location.

Although existing OSHPD processes could be utilized, substantially larger numbers of loan repayment contracts with dental graduates (and their practice sites) would increase the need for staff resources for program administration, contract management, and accounting. Increased federal primary care cooperative agreement funding might be one possible mechanism for meeting the anticipated additional costs.

There are likely some areas where a state program would differ substantially from the federal program. In both the nationwide NHSC loan repayment program and the CSLRP, there are major consequences for any provider who defaults on his or her obligation. Even though it is important to have disincentives and penalties for any providers who fail to fulfill contracts, the federal formulas for determining penalties for default often yield results that appear too severe.

These are two hypothetical situations in which the default penalties are particularly troublesome. Dentist A loses a position two months into practice. The ensuing default requires not only repayment of all loans repaid plus interest, but an “unserved obligation penalty” of \$1000/month for the remainder of the contract -- \$22,000 above the repaid loans plus \$25,000 advanced for the first year to repay the loans, plus interest. This would require payments of at least \$47,000. Dentist B has to leave a position 22 months into a 24-month obligation. The dentist is liable for \$2000 for the “unserved obligation penalty”, but receives no credit for the 22 months served and must repay all of the loan repayment funds received plus interest. This could total at least \$52,000. The dentist does have the opportunity to find another eligible site, but there is no guarantee that an alternative site would be available. A state program might be structured to take into account potentially relevant facts such as service time already served and the circumstances that led to a default situation.

Question Three: Should the State operate a program where private dentists’ offices and part-time dental practices could be eligible sites for service for loan repayment recipients?

Placement of CSLRP-assisted providers is limited to public and private non-profit healthcare entities. In the case of dentists, all of the 20 loan repayment awards to date have gone to individuals practicing in 15 clinical sites (see Appendix C). All recipients have been required to work at least 40 hours per week at their authorized clinical sites.

An alternative approach for a State-funded loan repayment program might be to require compliance with the above enumerated criteria for certified eligible CSLRP sites, but permit private practice dentists to work part time at such sites in exchange for loan repayment. Such loan repayments would presumably be associated with rates set in proportion to the amount of time spent practicing at the eligible site.

This might prove to be a popular option for dentists who are building a private practice, but are interested in committing specified service in a community health center, county clinic, school health program, or other safety net site on a part-time basis. For cost-effectiveness purposes, part-time

contracts might be limited to 40 percent time (16 hours a week) or above, since the administrative costs of contracts that yield fewer hours a week would be the same as those for persons with full-time obligations. The receiving organization would be responsible for ensuring the availability of the required match funding.

Both public and private non-profit health services organizations are subject to periodic reviews by governmental and health facility accreditation organizations, and are part of the primary care safety net. A part-time practice in such a setting could be audited to assure compliance with all terms of the loan repayment contract.

The State would have the principal fiduciary and administrative responsibility for assuring that the loan repayment recipient's time and service are accounted for properly, that the practice meets State requirements for patient access regardless of ability to pay, and that the practice is economically stable.

There are many private general dentists that serve Denti-Cal, Healthy Families or other underserved population groups or generally underserved rural areas. These dentists reasonably may be categorized as "safety net providers." However, the costs for establishing and maintaining economically viable dental practices in low-income areas or for low-income populations are considerable, and the best-intentioned of dentists may underestimate the difficulty of achieving economic viability.

Thus, establishing private practice sites eligible for loan repayment likely would require the promulgation of new rules or regulations that would include the retention and inspection of compliance-related documentation. Considerable care would be required to establish reasonable rules for ensuring that participating private practices are increasing access to dental care for those in need.

If the State has a fiduciary responsibility to assure that the dental loan repayment funds are not used for service in inappropriate settings, how is that responsibility to be met? In any discussion of establishing a program with a "private practice option" such as is suggested by AB 668, a decision would need to be made as to whether the State administers it "passively" or "actively." If passively administered, it may be sufficient for participating dentists to certify that their practices meet applicable requirements. Such requirements would almost certainly include the expectation not to discriminate based on ability to pay.

An alternative may be to establish rules and guidelines for determining what the minimum requirements of a participating private practice are (such as a practice's policies on reimbursement for patient care), and for monitoring the practices through periodic site visits and review of financial records. However, this alternative significantly increases the administrative costs of the program, and likely will diminish the enthusiasm for private practices to participate in loan repayment arrangements.

Perhaps a feasible approach to establishing a private practice option is to develop criteria for "pilot private dental practices" that meet legislative intent for participating "safety net" dental providers. The eligibility criteria for the pilot practices could be developed with substantial public input. Practices that meet the criteria could apply to be participants in a five-year dental loan repayment pilot project, for example. A process for monitoring and evaluating the pilot projects would be established that would advise legislators and policy-makers as to whether the private practice option

should be terminated, continued as pilot projects, or broadened to include all private practices that meet general criteria.

Question Four: How might a State Dental Loan Repayment Program, not using NHSC funds, be financed?

The previous discussion has suggested that the feasibility exists within OSHPD to create a State Dental Loan Repayment Program that utilizes contractual and administrative processes of the CSLRP, but where eligibility to be a participating loan repayment recipient or practice site is determined by the State. In fact, OSHPD, through the Health Professions Education Foundation [HPEF], funds loan repayment contracts through two mechanisms. Previous legislation (Chapter 252, Statutes of 1988) established a continuously appropriated fund derived from nurse licensure fees, administered by HPEF to fund nursing school loan repayment contracts. HPEF also accepts grants from the non-profit sector and private sector contributions, and have authorized these revenues for dental loan repayment contracts.

Thus, four sources of revenues have been used by OSHPD to fund health professional loan repayment funds: (1) federal funds through the NHSC program, (2) general fund appropriations, (3) professional licensure fees earmarked for loan repayment programs, and (4) contributions to the Health Professions Education Foundation. A source of ongoing revenue from any one or any combination of these sources might be sufficient to establish a health professions education dental loan repayment program.

Question Five: How will a new State Dental Loan Repayment Program interrelate with existing loan repayment activities within OSHPD?

OSHPD plans a systematic review of each of its available dental loan repayment programs and contract processes, with the objective of establishing department-wide policies to structure and administer these programs appropriately (within the restrictions of the funding sources and levels of available funding).

Likely results of the review will include the designation of the CHMPC as the principal focus for declaring shortage areas for medical and dental services and the determination of whether CHMPC or HPEF should take the lead role in advising on and codifying departmental loan repayment policies. The review would also seek to determine how the various actual and potential programs could be structured and interrelated to maximize their access-enhancing benefits and available funding levels.

APPENDIX A

Dental Shortage Area Maps

*These maps provided courtesy of University of California,
San Francisco Center for Health Professions (UCSF-CHP)*

**Shortage Area Definitions (based on Dentist-to-Population Ratios)
as shown in the following maps:**

Non-Shortage Area = 1: <4,000

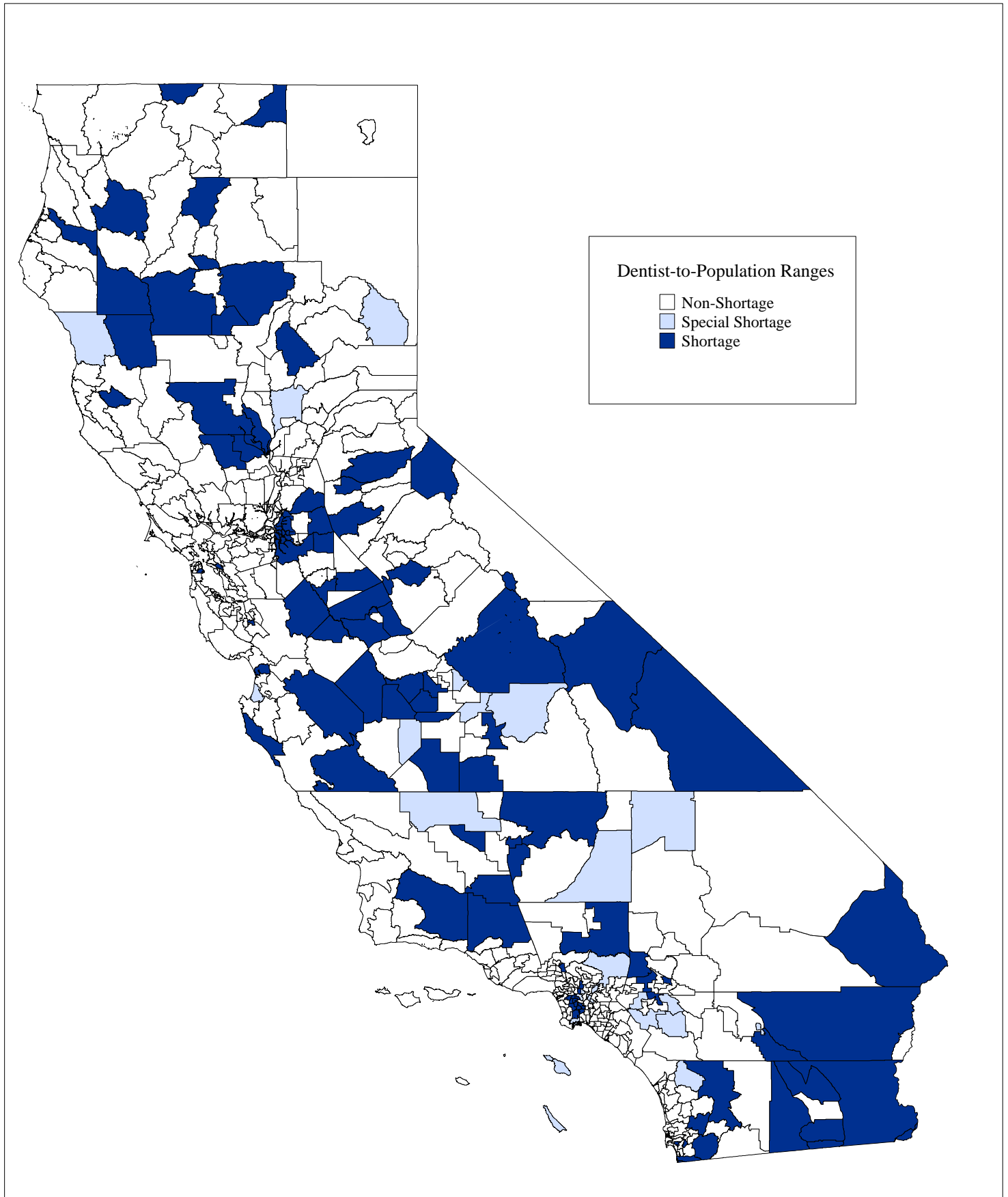
Special Shortage Area = 1:4,000-5,000

Shortage Area = 1:5,000 or >

Map 1

MSSAs with a Shortage of Primary Care Dentists

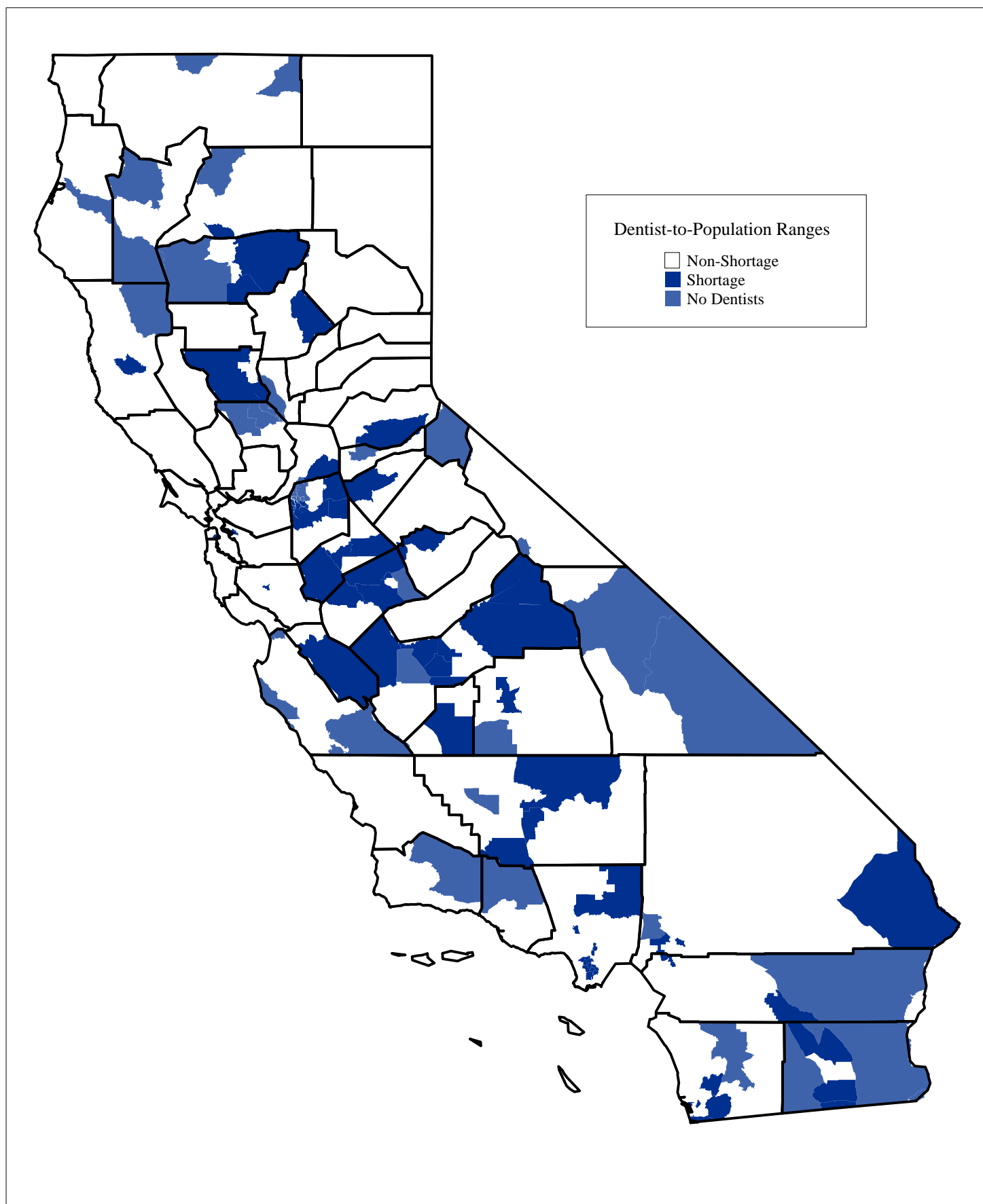
California, 1998



Sources: ADA (1998), OSHPD (1998), MapInfoDATA (1998)

Map 2

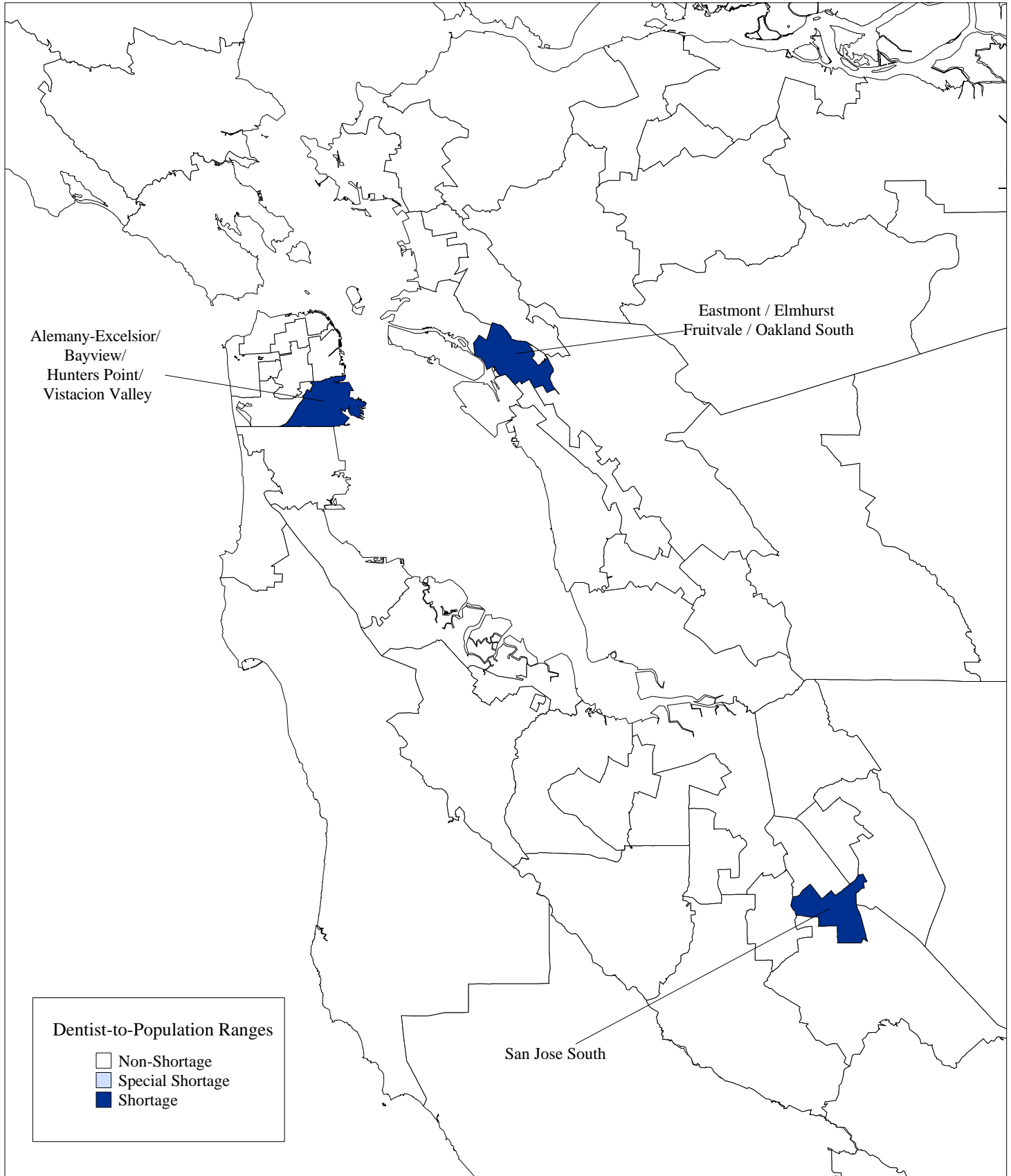
MSSAs with a Shortage of Primary Care Dentists California Counties, 1998



Map 3

MSSAs with a Shortage of Primary Care Dentists

San Francisco Bay Area, 1998

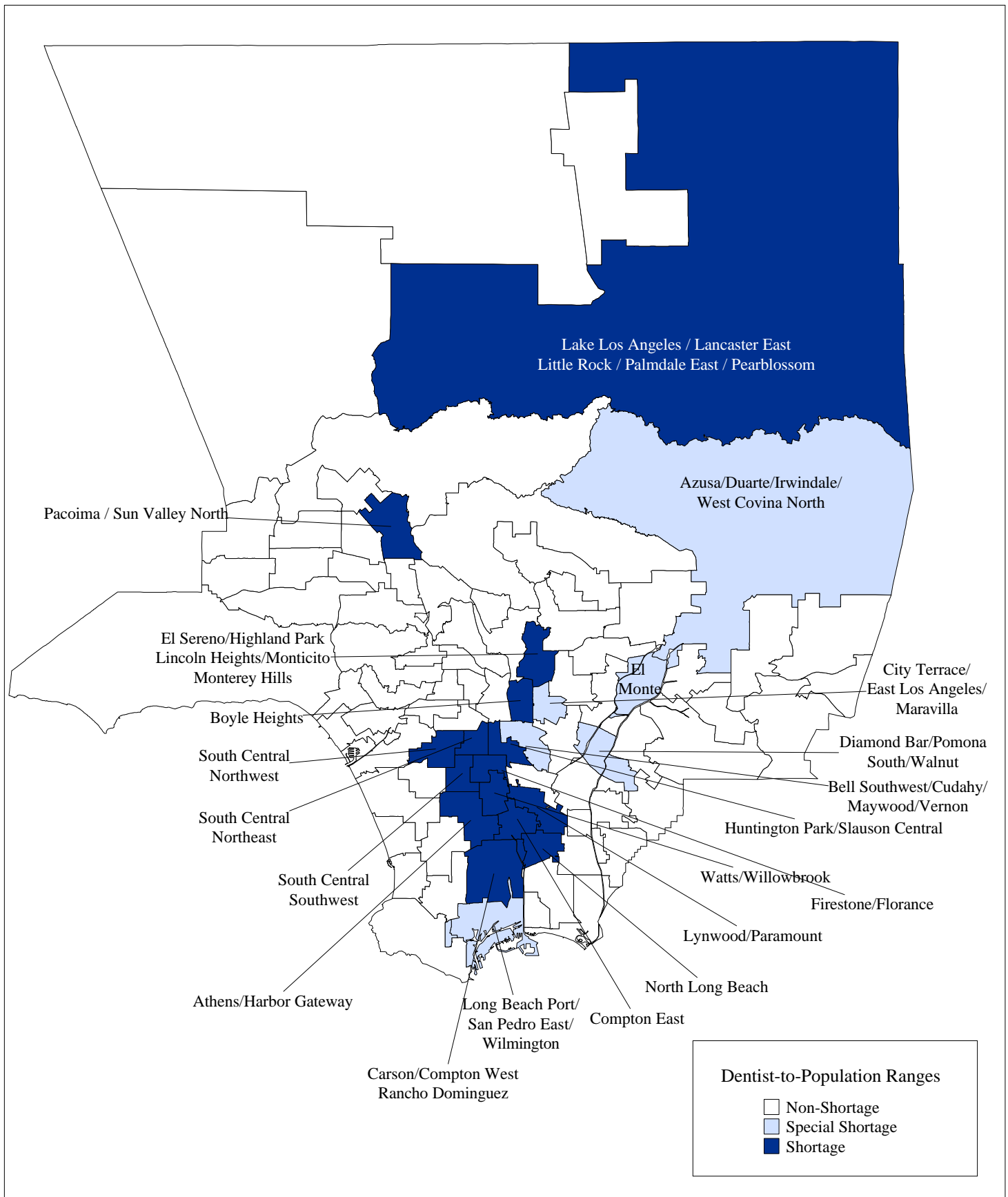


Sources: ADA (1998), OSHPD (1998), MapInfoDATA (1998)

Map 4

MSSAs with a Shortage of Primary Care Dentists

Los Angeles County, 1998

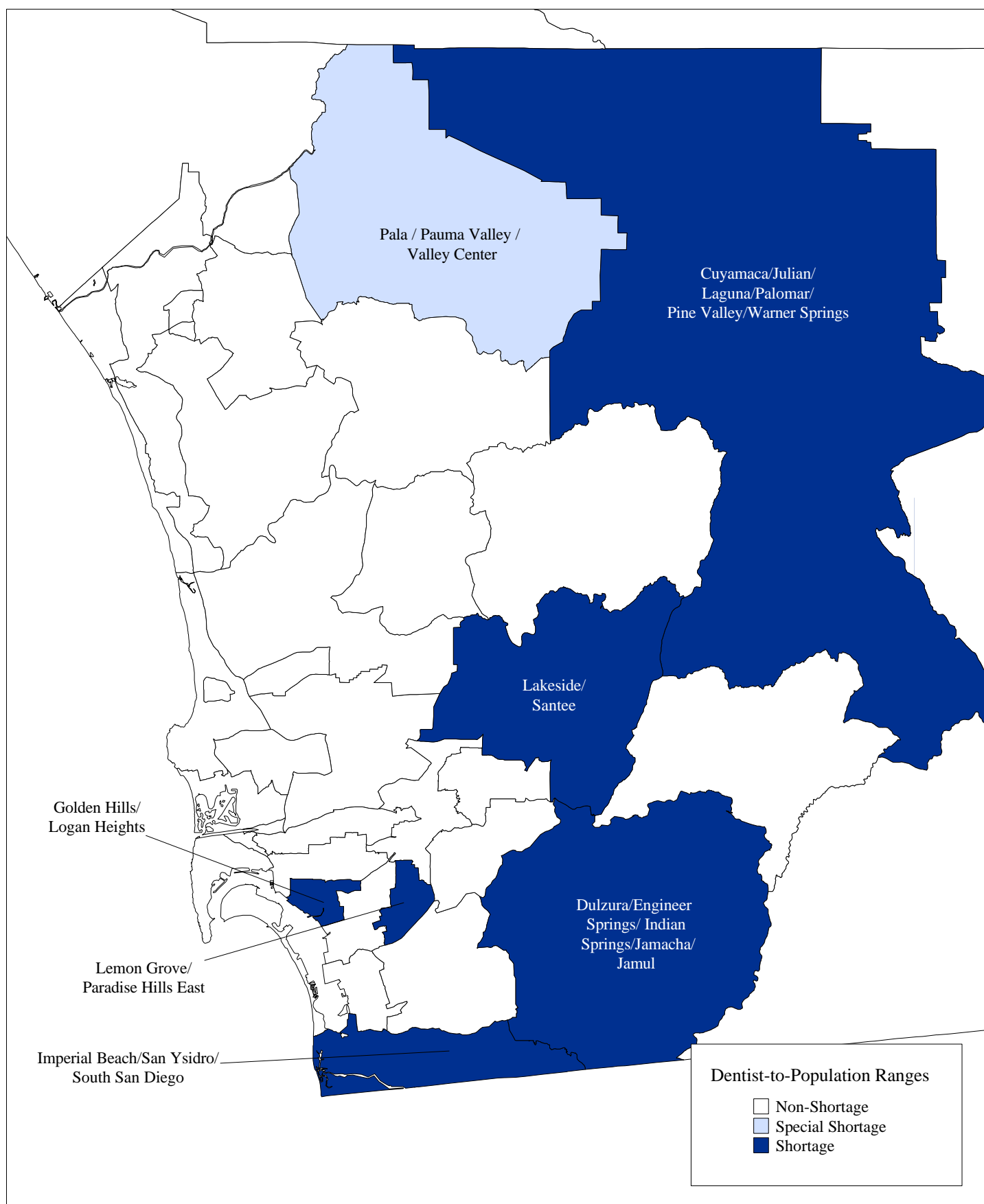


Sources: ADA (1998), OSHPD (1998), MapInfoDATA (1998)

Map 5

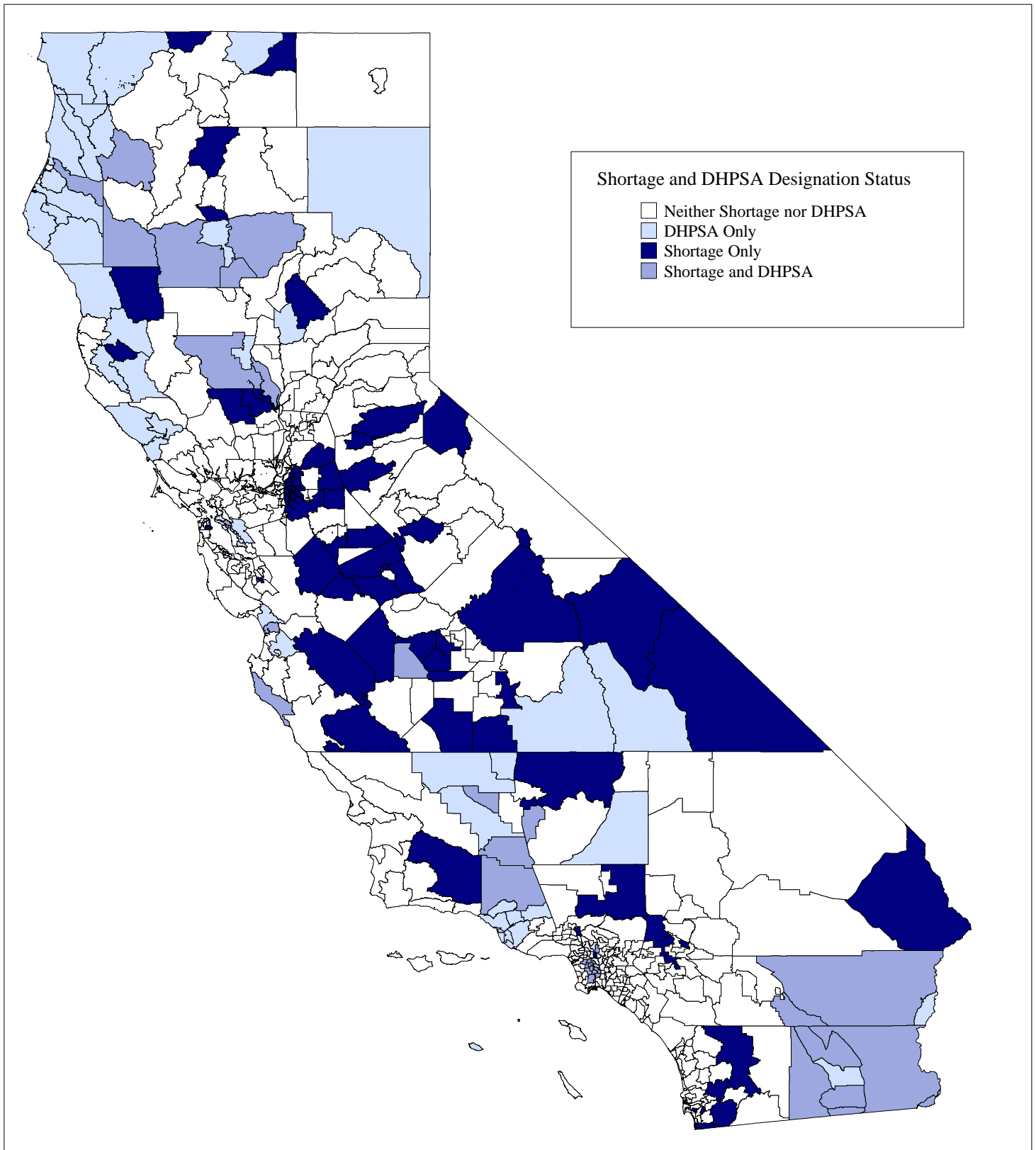
MSSAs with a Shortage of Primary Care Dentists

San Diego County, 1998



Map 6

MSSAs with a Shortage of Primary Care Dentists and Dental Health Professional Shortage Areas as currently designated by the Federal Division of Shortage Designations California, 1998



Sources: ADA (1998), OSHPD (1998), MapInfoDATA (1998)

APPENDIX B

Allocation of CSLRP Positions by FFY of Initial Contract Awards

Generally, initial loan repayment contracts are made for two years and charged against the FFY appropriation in effect at the time. Whenever contracts are amended to add a third and/or fourth year, the additional funds required are charged against the then current FFY.

Program Year		# of Awards	Rural	Urban	Disciplines						MD/DO Specialties			
					MD	DO	PA	NP	NM	DDS/DMD	FP	IM	Ped	Ob/Gyn
1 (91/92)		28	11	17	24	2	2	0	0	0	21	1	3	1
2 (92/93)		14	6	8	13	0	0	0	1	0	9	3	0	1
3 (93/94)		18	6	12	12	1	4	1	0	0	8	1	2	2
4 (94/95)		30	11	19	24	2	2	1	0	1	18	4	4	0
5 (95/96)		31	12	19	20	2	6	3	0	0	14	4	4	0
6 (96/97)		32	10	22	15	2	7	5	0	3	11	2	0	4
7 (97/98)		36	10	26	20	2	10	4	0	0	13	2	6	1
8 (98/99)		22	10	12	7	4	3	8	0	0	11	0	0	0
9 (99/00)		34	16	18	19	2	3	5	1	4	13	2	4	2
10 (00/01)		29	13	16	14	1	6	3	0	5	7	1	4	3
11 (01/02)		28	17	11	18	1	2	0	0	7	13	6	0	0
TOTALS		302	121	181	186	19	45	30	2	20	138	26	27	14

MD=Medical Doctor

DO=Doctor of Osteopathic Medicine

PA=Physician Assistant

NP=Nurse Practitioner

NM=Nurse Midwife

DDS=Doctor of Dental Surgery

DDM=Doctor of Dental Medicine

FP=Family Practice

IM=Internal Medicine

PED=Pediatrics

Ob/Gyn=Obstetrics and Gynecology

APPENDIX C

Sites of All CSLRP Dental Awards by Program Year Through 6/30/02 Total Awards: 20

PROG YR	END	START	TERM	SITE	CITY	COUNTY	AMOUNT
11	3/3/04	3/4/02	2	Family HealthCare Network-Visalia	Visalia	Tulare	\$20,032.00
11	2/11/04	2/12/02	2	Family HealthCare Network-Porterville	Porterville	Tulare	\$25,000.00
11	1/17/04	1/18/02	2	Clinica de Salud-Sanborn	Salinas	Monterey	\$15,991.00
11	1/17/04	1/18/02	2	Lakeside Clinic	Lakeport	Lake	\$25,000.00
11	12/25/03	12/26/01	2	Family HealthCare Network-Porterville	Porterville	Tulare	\$25,000.00
11	12/18/03	12/19/01	2	La Clinica de La Raza	Oakland	Alameda	\$25,000.00
11	12/13/03	12/14/01	2	Clinica Sierra Vista, Inc.	Lamont	Kern	\$25,000.00
7				YEAR 11 TOTALS			\$161,023.00
10	12/3/04	12/4/01	3	La Clinica de La Raza	Oakland	Alameda	\$41,554.00
10	9/27/03	9/28/01	2	United Health Centers of the San Joaquin Valley, Inc.	Parlier	Fresno	\$7,909.00
10	3/11/03	3/12/01	2	Clinica Sierra Vista, Inc.	Lamont	Kern	\$25,000.00
10	1/29/03	1/30/01	2	Shasta Community Health Center	Redding	Shasta	\$25,000.00
10	11/26/02	11/27/00	2	Feather River Tribal Health	Oroville	Butte	\$3,076.00
5				YEAR 10 TOTALS			\$102,539.00
9	9/10/04	9/11/00	4	Russian River Health Center, Inc.	Guerneville	Sonoma	\$60,000.00
9	4/16/03	4/17/00	3	Clinica Sierra Vista, Inc.	Lamont	Kern	\$42,500.00
9	10/29/02	10/30/00	2	Happy Camp Dental Clinic	Happy Camp	Siskiyou	\$25,000.00
9	3/30/02	3/31/00	2	Clinica Sierra Vista, Inc.	Lamont	Kern	\$19,967.48
4				YEAR 9 TOTALS			\$147,467.48
6	7/31/99	8/1/97	2	Native American Health Center	Oakland	Alameda	\$16,614.52
6	1/12/99	1/13/97	2	Buttonwillow Health Center	Buttonwillow	Kern	\$12,316.63
6	11/17/98	11/18/96	2	Del Norte Community Health Center	Crescent City	Del Norte	\$25,000.00
3				YEAR 6 TOTALS			\$53,931.15
4	8/31/97	9/1/95	2	Clinica De Salud-Soledad	Soledad	Monterey	\$34,750.00
1				YEAR 4 TOTALS			\$34,750.00
20				GRAND TOTALS			\$499,710.63

*No awards were made to dentists during program years 1, 2, 3, 5, 7 and 8.

APPENDIX D

Composition of Oral Health Advisory Council Organizations With Whom Memoranda of Agreement Have Been Executed:

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Virginia Meek, DDS, Clinician (Alternate) (707) 468-1010
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Chairperson, Legislative Affairs Committee, CDHA
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Vicki Kimbrough, RDH

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California Hispanic Health Care Association:

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